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DATE NOTICE SENT TO ALL PARTIES: May/27/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: bilateral L4-5 transforaminal ESI with fluoro

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Anesthesiology

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is this reviewer's opinion that medical necessity for bilateral L4-5 transforaminal ESI with fluoro has not been established.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on XX/XX/XX when he was struck in the back XX. The patient has been followed for persistent low back pain as well as numbness and weakness involving the lower extremities. Prior treatment did include physical therapy without any significant benefit. Medications have included both muscle relaxants and neuropathic medications and anti-inflammatories with limited relief. Prior MRI studies of the lumbar spine noted disc bulging at L3-4. There was an extruded disc fragment noted at L4-5 with bulging at the L4-5 annulus. The study did not identify any clear nerve root impingement. The patient was followed through XX/XX/XX. At this point in time, the patient had not had any epidural steroid injections approved. The patient's physical exam did note tenderness in the lumbar region with moderate pain during range of motion testing. There were trace reflexes noted in the lower extremities at the patella. The patient did ambulate with an antalgic gait and had radicular pain following an L5 distribution. The patient was then seen on XX/XX/XX with continuing radicular complaints. This physical exam noted tenderness and loss of range of motion in lumbar region. There was a noted absent patellar and ankle reflex involving the right lower extremity. No motor weakness was noted. In the left lower extremity, there were also absent patellar and ankle reflexes with intact strength. Electrodiagnostic studies performed at this evaluation were stated to show no significant findings. The proposed epidural steroid injection was denied by utilization review as there was no evidence of significant anxiety to support sedation which was requested. It was noted the reviewer was recommending the epidural steroid injection. The request was again denied as there was lack of documentation regarding radiculopathy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The records provided for review note ongoing complaints of pain in the low back and lower extremities despite conservative management to include several medications as well as physical therapy. MRI studies of the lumbar spine did note a disc herniation at L4-5; however, there did not appear to be any evidence of nerve root compression or impingement. In review of the patient's most recent physical exams, XX noted pain in L5 distribution but no specific neurological findings. In

review of the most recent evaluation, there were trace absent reflexes in the lower extremities symmetrically. There was no motor weakness or sensory deficit. Furthermore, electrodiagnostic studies were negative for evidence of radiculopathy. Given the lack of objective evidence regarding an unequivocal diagnosis of lumbar radiculopathy, this reviewer does not feel the records meet guideline recommendations regarding epidural steroid injections. Therefore, it is this reviewer's opinion that medical necessity for bilateral L4-5 transforaminal ESI with fluoro has not been established and the prior denials remain upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)